CHIA.
center for health information and analysis

Archived Questions from MA APCD User Workgroup Meetings

From Meeting held on February 25th, 2014

Q: We received [Element X], but it is incompletely populated or not populated.

A: Consult the MA APCD Data Guides before requesting an element. Note edit levels and thresholds. In the coming months, we plan to publish data profiles on the largest carriers.

Q: We realized there are some additional elements we need, but did not request.

A: To request an amendment, please send an email to APCD.data@state.ma.us

Q: We need to link/define members across the files we received (e.g., Medical Claims, Member Eligibility, Pharmacy), but we are not sure how to do this. Are there variables that allow us to do this?

A: Records between claims files and eligibility files should be linked via the OrgID and the Hashed Carrier Specific Unique Member ID. This may not always work, due to variation in submission by the carriers. Alternatively, use the Member Enterprise ID (MEID).

Q: How do we determine "final" paid adjudicated status claim. Do we use the version identity of the claim? Do we use the fact that a "former" version of the claim is populated?

A: In Release 2.1, CHIA included a "highest version" flag for the largest carriers.
For more details on this, please see relevant sections of MA APCD Release 2.10 Documentation Guides.

Q: Some plans submitted lookup tables for medical specialties and some did not. How do we determine medical specialties for those Plans that did not submit lookup tables? Can we assume that they use some form of national taxonomy?

A: For descriptions of Specialty data element codes, users should first link orgid + data_element_code to TlkpCarrierSpecificCodes_All_Redacted. Then, the unmatched should be linked to the standard provider specialty codes as described in the relevant Data Documentation Guide.

For description codes of PV029, users should link orgid + data_element_code to TlkpCarrierSpecificCodes_All_Redacted.

From Meeting held on March 25th, 2014 and April 22nd, 2014

Q: Is there a way to identify overlap between submissions from carriers and Third Party Administrators in the data and eliminate duplicate enrollees/data?

A: Use ME028 (Primary Insurance Indicator), MC038 (Claim Status), MC095 (COB / Third Party Liability), and MC096 (Other Insurance Paid Amount) to capture instances of COB. All of these are "A" level fields.

Q: There are member IDs and subscriber IDs that appear in the medical and pharmaceutical claims data that are not in the member eligibility files. What are these and how do we deal with them?

A: There are instances where insurers receive claims for processing that, due to incomplete information, do not validate against their eligibility data.

CHIA has observed this and has worked with carriers to resolve.

In the meantime, depending on your analysis, you may choose to use the non-matching claims or exclude them.

Q: Can I find the MA GIC claims payers in the MA APCD if I get the product name?

A: You would need ME060, which is a Level 3 data element. Level 3 data elements are generally available to state agencies only.

Q: In the Member Eligibility file there are fields for spouse plan types and medical coverage-GIC Only: will we need these fields for demographic break down by coverage types? Or would the spouse have their own record in the table?

A: These are Level 3 data elements (ME067-70).

Note they are C fields with a 1% threshold in Release 2.0 (Page 21 of the ME documentation). This means that these carrier-defined reference tables are not be well populated in Release 2.0.

Q: In the MC003 field, Insurance Code Type, I have a list of descriptions, but the list is missing codes MO and SP. Are there descriptions for those two codes?

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A: As reported on Page 14 of the MC file documentation, this is a "C" level field and thus are not edited for compliance against the lookup table.

MO is likely Medicaid Managed Care. SP is likely Supplemental Policy.

Q: **Within the Medical Claims File, sometimes within a hospitalization, the Product ID (MC079) is different. How should we interpret this? Also, is the Member Eligibility File more accurate for Product ID (ME040), or can we rely on this field within Medical Claims File?**

A: We recommend that you use the Member Eligibility File and link to the Product File.

Q: **In Pharmacy Claims File, the Member State (PC015) lists 83% of the pharmacy claims in Massachusetts (MA). Should this be higher since it is the member state and not the place where the prescription was filled? (Please Note: 93% of Member Eligibility File shows that member state is MA, and 95% in Medical Claims File.)**

A: Our data includes out-of-state members, including GIC enrollees, family members of MA insureds living out of state, college students as well as out-of-state residents such as retirees.

Q: **In the Member Eligibility File, we find some payers that have more unique Carrier Specific Unique Subscriber ID (ME117) than Carrier Specific Unique Member ID (ME107). Please explain.**

A: There are instances where the payers are not giving us the actual unique member ids.

Q: **Are Product Enrollment Start Date (ME041) in the Member Eligibility Files that are very far (>5+ years) in the past credible?**

A: Enrollment dates are as reported. We recommend researchers use Month (ME005) within year(s) of analysis.

Q: **In the Medical Claims File, what should be reported in the deductible field? Our understanding is that we should receive in 2009 the total deductible paid for the year in each claim. In 2010 and 2011, we expect a running total of the deductible paid to date. Based on a spot check of the claims, it does not appear that either of these is true in some cases.**

A: Deductible Amount (MC067) is the amount of the claim line that the insured member is responsible for paying out of pocket. Deductible amounts can be at the individual level or family level, depending on plan design. The same member may have different deductibles for specific services, such as ER visit, inpatient stay etc. A member may also have benefits where the insurer covers costs for a service before the member has met their deductible. Note that Deductible Amount (MC067) is not a sum of the member's deductible payments over the course of the benefit year. It reflects the amount paid by the member for that claim.

Q: **There are a number of products that are overlapping in time (i.e., both active in January 2010) that have different characteristics in other fields. How should we determine which product information to use?**

A: Link by Date of Service. We recommend that you use the Member Eligibility File for this type of analysis. This could be due to dual or multiple eligibility, as well as members who switch health plans during the year; our data will account for a member who switches from Tufts Health Plan to Harvard Pilgrim Health Care, for example, as two different people in lieu of one person. A Member Enterprise ID in Release 2.1 of the MA APCD will help users link people across payers.

Q: **More than 4 million observations have Linking Plan Provider ID (PV002), but do not have National Provider ID (PV039) cleaned. What is the cause of this? Is it possible that these are RNs or PAs, or would these be coded under the National Provider ID (PV039) of the supervising physician?**

A: Yes, RNs and PAs could be coded under the NPI of the supervising physician.

Q: **Some payers appear to be submitting Member Eligibility Files records each month, while others submit only for December. Is there any reason for this, and should the information in the records be interpreted differently?**

A: Yes, payers submit a 24 months of Member Eligibility data each month. Smaller payers are allowed to submit less frequently.

Q: **What does "rolling 24 months" mean?**

A: Rolling 24 months refers to two years of data. In other words, data submitted in December 2013 reflect data from November 2011 to November 2013. When December 2013 data is added, November 11 data "rolls off."

Q: **We have a question about how to do versioning. We do not have the Highest Version Flag (Derived – MC10) or the Medical Claim ID (Derived MC – 5) field. Without the Highest Version Flag (Derived – MC10), we have to apply the versioning rules ourselves but we are unable to do this without the Medical Claim ID (Derived MC – 5). Is it possible to do the versioning without these, and if not, do we need to get the additional fields?**

A: Versioning logic is carrier specific and requires Medical Claim ID (Derived MC – 5). Additional fields can be obtained through filing an amendment to your MA APCD application. Forms are available on IRBNet.

Q: **There are about 8 million observations that are missing a start date, and 31 million that are missing an end date. We anticipate that active provider affiliations will be missing an end date. What does it mean for the start date to be missing?**

A: The Provider Affiliation Start Date (PV062) and Provider Affiliation End Date (PV063) describe the providers' affiliation/association with a parent entity, such as a billing entity, corporate entity, doctor's office, provider group, or integrated delivery system. If Provider Affiliation Start Date (PV062) is blank, and provider is affiliated only with itself, that is Provider Affiliation (PV056) = Provider ID (PV002). A blank Provider Affiliation Start Date (PV062) means that particular Provider ID (PV002) does not render services.

Q: **Is cleaned deductible a field you can request?**

A: No, the deductible field was not one of the fields selected for cleaning by CHIA.

Q: **How important is the versioning in your analysis? (i.e., how much does it affect spending, etc.)**

A: Versioning is extremely important in your analysis. Not using the highest version of a claim line will yield questionable results.

Q: **Once an application for data is approved, when is payment required?**

A: Payment is required before we can mail your extract. CHIA's Legal Department will send you an invoice with the amount owed.

Q: **How long from our application being submitted will it take to get the data?**

A: It takes generally from 3-5 months to receive your data extract, depending on how many applications are in queue and whether or not MassHealth data has been requested.

Q: **Some carriers did not report the deductible amount in member file, how confident that the deductible info in product file can be used?**

A: The Member Eligibility File has eight different deductible fields:

ME049 – Member Deductible: Annual maximum out of pocket Member Deductible across all benefit types
ME050 – Member Deductible Used: Member deductible amount incurred
ME111 – Medical Deductible
ME112 – Pharmacy Deductible
ME113 – Medical and Pharmacy Deductible
ME114 – Behavioral Health Deductible
ME115 – Dental Deductible
ME116 – Vision Deductible

The Product file has two different deductible fields;
PR012 – Annual per Person Deductible
PR013 – Annual per Family Member Deductible

Member Deductible (ME049) has a 90% filing threshold and Annual per Person Deductible (PR012) has a 100% threshold, therefore an expected higher rate of completeness. Please also note you would see the codes '000' if the member has no deductible. When linking to information on the member's product associated with a member claim, the link between the Product ID (ME040) in the Member Eligibility File and the Product ID (PR001) in the Product File is a strong one-way link.

Q: **Race/ethnicity and language information are missing in Member Eligibility File. Do you expect any improvement in the future?**

A: As noted in the MA APCD documentation, race/ethnicity and language info have low thresholds. Payers have had difficulty obtaining this data as part of their claims adjudication processes. However, Case Mix data which is collected by the hospitals for inpatient stays, ER visits and observation stays is presently a better source for race/ethnicity and language information.

Q: **Member Deductible (ME049) in the Member Eligibility File is not consistent with the annual Per Person Deductible Code (PR012) in Product File. Do you recommend we use the Member Eligibility File?**

A: Yes, we recommend you use the Member Deductible (ME049) in the Member Eligibility file. Please also note that a member can have multiple products that have different deductible amounts associated with different services.

Q: **If I procure Medicare data from CMS can it be linked to MA APCD?**

A: Approval to link the MA APCD with external data sources must go through the CHIA review process and is subject to CHIA's Data Use Agrement with CMS.

From Meeting held on May 27th, 2014

Q: Is there a way to identify if a patient died during an admission?

A:

<u>How to determine if a patient died using Case Mix Data:</u>

Outpatient Hospital Emergency Department Data Deaths

Departure Status Code	Description
9	Dead on Arrival (with or without resuscitative efforts in the ED)
0	Died during ED Visit

Outpatient Hospital Observation Stay Data Deaths

Departure Status Code	Description
5	Expired

Inpatient Hospital Discharge Data Deaths

Discharge Status Code	Description
20	Expired

How to determine if a patient died using MA APCD:

Discharge Status (MC023)	Description	Type of Bill on Facility Code (MC036)	Description	Site of Service -on NSF/CMS 1500 Claims (MC037)	Description
20	Expired	11	Hospital Inpatient		
20	Expired	12	Hospital Inpatient (Medicare Part B Only)		
20	Expired	13	Hospital Outpatient		
20	Expired	14	Outpatient Diagnostic Facility		
20	Expired	18	Hospital Swing Bed		
20	Expired	21	Skilled Nursing		
20	Expired	22	Skilled Nursing (Medicare Part B Only)		
20	Expired	23	Skilled Nursing Outpatient		
20	Expired	32	Home Health Inpatient		
20	Expired	33	Coordinated Home Care (Medicare Part A) Discontinued 10/2013		
20	Expired	66	Intermediate Care - Religious Non-Medical Outpatient Health Care		

20	Expired	72	Hospital Based or Independent Renal Dialysis		
20	Expired	81	Non-Hospital Based Hospice Facility		
20	Expired	82	Hospital Based Hospice Facility		
20	Expired	83	Ambulatory Surgery		
20	Expired	85	Critical Access Hospital		
20	Expired	86	Residential Facility		
20	Expired	89	Other Outpatient Facility		
20	Expired			21	Hospital Inpatient
20	Expired			23	Emergency Dept.
20	Expired			31	Skilled Nursing Facility
20	Expired			99	Other Service Place
40	Expired at Home	81	Non-Hospital Based Hospice Facility		
40	Expired at Home	82	Hospital Based Hospice Facility		
40	Expired at Home	33	Coordinated Home Care (Medicare Part A) Discontinued October 2013		
41	Expired in a Medical Facility	81	Non-Hospital Based Hospice Facility		
41	Expired in a Medical Facility	82	Hospital Based Hospice Facility		
42	Expired Place Unknown	81	Non-Hospital Based Hospice Facility		

Q: There are 982449 members with an 'Unknown' gender and another 60255 members with a null gender. Is there any way to get more complete Gender information? In the Eligibility File there are Members with 'Unknown' Gender (ME013) and Members with a null Gender. Is more complete Gender Information available?

A:

Gender (ME013) in Eligibility File:

QA Metric Description	QA Metric Justification	Metric Results
Blank Values	Percent of records where no data is entered in the field	3%

Data Format Errors	Values that are submitted as a lowercase letter need to be converted to an uppercase letter	Less than 0.001%
Invalid Values	Values are invalid if not within the lookup table	Less than 0.001%
Use of Valid Values	Values are within the lookup table.	96.99%

Gender (MC012) in Medical Claims File:

QA Metric Description	QA Metric Justification	Metric Results
Blank Values	Percent of records where no data is entered in the field	Less than 0.001%
Data Format Errors	Values that are submitted as a lowercase letter need to be converted to an uppercase letter	Less than 0.01%
Use of Valid Values	Values are within the lookup table.	99.99%

Q: Is using the Medicaid indicator the best way to identify whether a member has public/private insurance? If so, then should we use the Medicaid indicator field from the Eligibility file or from the medical/pharmacy claims file?

A:
Insurance Type Product Code Medical Claims (MC003)
92% Threshold
0.17% Missing Data

Insurance Type Product Code Member Eligibility (ME003)
96% Threshold
Less than 0.0005% Missing Data

From Meeting held on June 24th, 2014

Q: What is the difference between "Single Use" and "Multiple Use"?

A: One extract for one project is considered a "Single Use." One extract for multiple projects is considered "Multiple Use." A research project can have multiple project goals. However, it is still considered single use as long as those goals are all tied to a single research purpose.

Q: How do we add new users to our project?

A: New users must sign confidentiality agreements. Send an email to chia-apcd@state.ma.us requesting a new user and we will unlock your IRBNet project so you can upload the confidentiality agreement.

Q: When do the fees need to be paid?

A: The application fee must be received before we begin the review process. The data fees must be paid before we deliver the data extract to you.

Q: How are fees calculated?

A: Fees are calculated per file per extract. You can get multiple years of data in one extract.

Example (based on Level 2, Others – Single Use)
2013 Medical Claims File = $7,500
2011, 2012, 2013 Medical Claims File = still $7,500

From Meeting held on August 26th, 2014

Q: The Member Deductible (ME049), Medical Deductible (ME111), Pharmacy Deductible (ME112), and Behavioral Health Deductible (ME114) seem to be categorical variables. For instance for Member Deductible, values range from 0-60, with smaller step-wise increments in the lower values (0,1, 1.5, 2, 2.4, 4, 3.5, 4, 5, 6, 7….40, 50, 60 etc). This does not match what is specified in the submission guidelines.

A: For currency fields, CHIA imputes a decimal. Note that '0' is a value (not null).

Q: Around 54% of members in the claims sample (when de-duplicated by payer specific member code) have no value in the Member Deductible (ME049) variable. Do you have any thoughts on why these values might be missing for those members?

A: A-level fields can have a value of '0'. Please note that member deductible (ME049) is not the same as medical deductible (ME111), as described in the Submission Guide. Note that about 90% of ME049 values are expected to be valid and that carriers may request a variance for a threshold lower than 90%.

Q: The Product File Layout makes references to a Lookup Table similar to the other files (Medical Claims, Dental Claims, etc), but there does not seem to be an appended lookup table in this file's documentation. Could you point us to the correct document to find the file element Lookup Table for the Product File? We do see similar information in the Product File submission guide – can we assume those definitions are the same as what would be found in the Lookup Table?

A: Tables are embedded in the Submission Guide. Please note that tables will be added to the Release 3.0 Documentation Guide.

Q: What is a Coordinated Care Model (PR014) for MA APCD purposes? Does this include HMOs? Currently appears that 75% of patients are in a "coordinated care model." The submission guide states that "1" means "Member's care is clinically coordinated/managed," but we were wondering if you have further insight into how the payer determines or tracks this field.

A: With the 649,759 Products that have Code 1 (Yes) for the Coordinated Care Model, 88.98% of those products are attributable to HMOs. For Release 2.1, this is a C-level field. Payers provide information on their website about their Coordinated Care Models. In addition, payers are

indicating on their websites their support of GIC's Centered Care Initiative. For more information on this initiative and how it relates to coordinated care, see GIC website.

Q: What is a Health Care Home (ME035-39) for APCD purposes? Currently 7% of patients are reported as in one. The list of named Health Care Homes includes large hospitals and individual providers. The submission guide defines these as "patient centered medical home," so does that mean that these patients were assigned to a recognized PCMH as of the date of submission?

A: Approved PCMH is determined by each carrier using their own criteria. For B- and C-level fields, intake edits are applied but a file does not fail (as noted in the Documentation).

From Meeting held on September 23rd, 2014

Q: Does my entire system need to be encrypted or only the portion on which CHIA data (APCD/Case Mix) is being stored?

A: No; only the portion on which CHIA data is being stored.

Q: Is the MA APCD linkable to other datasets?

A: Yes, all types of linkages are feasible. Please note that all proposed linkages to other datasets must be approved by CHIA.

Q: Will I be able to identify nurse practitioners as plan rendering providers from data element MC134? Will I have to use this element to link to the element PV002 on the provider file to obtain this information?

A: You need to link to PV002 in order to get information from the field PV022 (Taxonomy) which allows you to distinguish Nurse Practitioners. However, CHIA MA APCD profiling of Provider IDs in Medical Claims suggests that NPs may bill under the Attending Physician's ID since the Physician IDs exceeds NPs.

Q: Having looked through the Provider File, it seems as if, for a given National Provider ID, there may be multiple LinkingProviderID's. Is this because the LinkingProviderID is reported uniquely by each carrier, such that the same provider might have n LinkingProviderIDs from n carriers?

A: Correct. Each carrier assigns a unique provider identifier (PV002) for every service provider in its system (person or entity). CHIA is working to create a master provider list that would link physician records across payers.

Q: Do you know if it's possible in the Product File to see Medicaid plans within an OrgID?

A: Within the Product File, PR004 (Product Line of Business Model), contains the following codes for Medicaid:

MC = Medicaid FFS
MO = Medicaid Managed Care Organization
PC = Medicaid Primary Care Clinician Plan

Also ME003 (Insurance Type Code/Product) has the coding option "MO" for Medicaid Managed Care Organization. It is important to check both the eligibility and product file because there are

instances where a carrier might not have indicated the "MO" option in the product file but did do so in the eligibility file and vice versa.

From Meeting held on October 28th, 2014

Q: When can I apply for 2013 APCD data?

A: Release 3.0 application materials are expected to be ready in December 2014 and will be announced at this workgroup and via e-blast.

Q: The "Service Provider Number" (MC024) is listed as a linkage element but many of the records have a NULL value. We cannot link elements with NULL values.

A: For MassHealth and Health Safety Net, the Service Provider Number (MC024) is always as the Billing Provider (MC076), so they did not populate the field MC024. There are other carriers where that scenario is also true but they did redundantly populate the service provider number with the billing provider number.

Q: Is there an identifier for patients that is NOT their SSN? We would like to track patients across plans and over time, but would like to avoid accessing high-level identifying info such as SSNs.

A: CHIA has created in the MA APCD an MEID that allows you to track patients across plans and over time.

For more information, refer to our Master Patient Index presentation from last April: http://www.mass.gov/chia/docs/p/apcd/workgroup-meetings/2014-04-22-apcd-user-group-presentation.pdf

Q: Is it possible to determine race/ethnicity of a patient?

A: In the MA APCD, the eligibility file has race and ethnicity data but the completeness of that varies across carriers. [Thresholds for Race and Ethnicity are both 3%] Case mix data has more complete race and ethnicity data.

Q: Are payments to the Department of Mental Health or Department of Corrections included in the MA APCD?

A: Yes.

Q: We are interested in learning more about high-deductible health plans. Can we determine whether a plan is a HDHP in the product type field? (or is there another indicator that we could use?)

A: The Product File has field PR012 Annual Per Person Deductible Code which defines the Total Per Person Deductible for all benefits under this product using the following coding options:

000 No per person deductible
001 Deductible Total under $1,000
002 Deductible Total of $1,000 thru $1,999
003 Deductible Total of $2,000 thru $2,999
004 Deductible Total greater than $3000
999 Not Applicable

Q: If a claim is denied, we understand that it is not reflected in the MA APCD. Are there any instances where a denied claim might appear (i.e., initially denied but later paid, partially paid, or other circumstances)?

A: Yes, if a claim was originally paid then later denied or partially paid with specific claim lines denied.